



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

VICTORIA HOPKINS, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-2391-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

APRIL 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$307.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's request should be dismissed for the following reasons. Rule 133.307(c)(2) states in part '...the requestor shall provide the following information and records with the request for MFDR in the form an manner prescribed by the division. The provider shall file the request with the MFDR Section by an mail service or personal delivery. The request shall include...(J) a paper copy of all medical bill(s) related to the dispute....(K) a paper copy of each explanation of benefits (EOB) related to the dispute...(N) a position statement...(i) the requestor's reasoning for why the disputed fees should be paid...DWC60 packet shows the above items are missing. A rational administrative review cannot be done absent those items. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2014	CPT Code 99214 Office Visit	\$207.00	\$124.38
	HCPCS Code S9088 Services Provided in an Urgent Care Center	\$100.00	\$0.00
TOTAL		\$307.00	\$124.38

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
5. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services

Issues

1. Does the documentation support code 99214? Is the requestor entitled to reimbursement for code 99214?
2. Does the documentation support HCPCS code S9088? Is the requestor entitled to reimbursement for HCPCS code S9088?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

On the disputed date of service, the requestor billed CPT code 99214.

- CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

The Division finds that the requestor supported the billed service; therefore, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

- The 2014 DWC conversion factor for this service is 55.75.
- The Medicare Conversion Factor is 35.8228
- Review of Box 32 on the CMS-1500 the services were rendered in zip code 77546, which is located in Friendswood, Texas; therefore, the Medicare participating amount is based on locality "Galveston, Texas".
- The Medicare participating amount for code 99214 is \$79.92.
- Using the above formula, the MAR is \$124.38. The respondent paid \$0.00. The difference between amount paid and MAR is \$124.38, this amount is recommended for reimbursement.

2. On the disputed date of service, the requestor billed HCPCS code S9088.

- HCPCS code S9088 is defined as “Services provided in an urgent care center (list in addition to code for service).”

S9088 is a status “I” code that is not valid for Medicare purposes. S9088 is an “add-on” code that allows urgent care centers to be reimbursed for their higher cost of providing services. The Division finds that the requestor supported the billed service was rendered in an urgent care center; therefore, reimbursement is recommended.

HCPCS code S9088 does not have a relative value unit or payment; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203(f).

28 Texas Administrative Code §134.203(f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(f) which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of \$100.00 for HCPCS code S9088 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$124.38.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$124.38 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

01/21/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.